New Hampshire

ANTI-OBESITY MEDICATIONS

NH Medicaid Prior Authorization Request Form

Fax: 1-888-603-7696 Phone: 1-866-675-7755

First Health Services

Date of Medication Request: ___ ___ /___ ___ /___ ___ ___ ___

Section I: Patient Information and Medication Requested

Name: (Last, First) _____

NH Medicaid Number: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name: _____ Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Section II: Clinical History

1. Patient's Diagnosis: _____
2. Is the patient 16 years of age or older? ☐ Yes ☐ No
3. Has the patient failed to lose weight on a low calorie diet **AND** exercise regimen after at least a 3 month trial? ☐ Yes ☐ No
   Please explain: _____
   _____
4. Does the patient have BMI $\geq$ 30 kg/m^2 with no risk factors, or $\geq$ 27 kg/m^2 with at least one (1) high risk factor, or two (2) other risk factors?
   ☐ Yes ☐ No Patient's BMI: _____ Weight: _____ Height: _____ Date: ____/____/_____
5. Waist circumference: _____
6. Does the patient have any of the following high risk factors?
   ☐ Sleep apnea ☐ Type 2 diabetes
   ☐ Coronary heart disease ☐ Artherosclerotic disease
7. Does the patient have any of the following risk factors?
   ☐ Hypertension ☐ Dyslipidemia ☐ Cigarette smoking ☐ Osteoarthritis
   ☐ Gallstones ☐ Stress incontinence ☐ Gynecologic abnormalities ☐ Age
   ☐ Family history of premature heart disease ☐ Impaired fasting glucose concentration
8. Are there any contraindications to the use of this drug for this patient? ☐ Yes ☐ No
   If **Yes**, please explain: _____
   _____
9. Is there any additional information that would help in the decision-making process? If more space is needed, please use another page.
   _____
   _____
   _____

Section III: Prescriber Information

Name: _____ DEA Number: _____ _____ _____ _____ _____ _____ _____ _____

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Signature of Prescribing Provider